

DERRY COOPERATIVE SCHOOL DISTRICT

N.H. School Administrative Unit #10

SCHOOL HEALTH PHYSICAL EXAMINATION

Name of Student: _____ DOB: _____
Height: _____ Weight: _____ Urine: _____ HGB.HCT: _____ Lead Level: _____ BP: _____

Hearing & Vision Screening:

Skin/Scalp:

Nose/Mouth/Throat:

Neurological/Muscular:

Spine & Extremities:

Glands, Including Thyroid:

Chest/Breast:

Heart/Lung:

Abdomen:

Genitalia:

Allergies (Asthma, etc.):

Recommendations:

CHILD IS PHYSICALLY CAPABLE OF FULL ACADEMIC & PHYSICAL EDUCATION PROGRAM: ____ YES ____ NO

EXCEPTIONS:

ARE ALL IMMUNIZATIONS UP TO DATE ACCORDING TO NH REGULATIONS: ____ YES ____ NO

PLEASE ATTACH DOCUMENTATION OF ALL IMMUNIZATIONS

Date of Examination: _____ Physicians Signature: _____
Print Physician's Name: _____
Address/Telephone #: _____

PHYSICAL EXAMINATION COMPLETED WITHIN ONE YEAR PRIOR TO ENTERING PUBLIC SCHOOL
TRANSFER STUDENTS WILL NEED PHYSICAL IF ONE IS NOT IN RECORDS